

The maternity care experiences and needs of migrant
women with female genital mutilation living in
Australia

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Certificate of Original Authorship

I declare that this thesis is submitted in fulfilment of the requirements for the award of doctoral degree, in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Production Note:

Signature: Signature removed prior to publication.

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Dedication

This work is dedicated to my late mother, 'Parvin' who wished to see me at the top of the mountain of success. The woman who sacrificed her dreams for my growth and empowerment. She made me to be the person I am today and constantly motivated me to keep working toward creating the best version of myself.

My mother strongly fought with her whole tribe, traditions and culture to ensure I'd have all the potential opportunities and possibilities to be educated and empowered and achieve my dreams and goals. She taught me to be prepared and to stay strong in the face of challenges and difficulties with faith, resilience and humility. Her life is a constant source of inspiration for me.

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‘Embrace the struggles and let them make you stronger’

Dissemination

Peer reviewed publications

Turkmani, S., Homer, C.S.E. & Dawson, A. 2018, 'Maternity care experiences and health needs of migrant women from female genital mutilation–practicing countries in high-income contexts: A systematic review and meta-synthesis', *Birth*. 46 (1), pp.3 –14

This peer reviewed paper is included in Chapter Two of my thesis and was published during my PhD candidature. Below is the summary of contribution for each author.

Area of contribution	Percentage of contribution
Concept and design of the study	ST 90%, AD; CH 10%
Supervision and conduct of research	ST 80%, AD; CH 20%
Data analysis and interpretation	ST 75%, AD; CH 15%
Writing of the initial manuscript	ST 80%, AD;CH 20%
Manuscript revisions	ST 90%, AD; CH 10%

Technical publications

These background papers were also published during my PhD candidature, but they are not part of my thesis.

Turkmani, S., Homer, C., Varol, N. & Dawson, A. 2018, 'A survey of Australian midwives' knowledge, experience, and training needs in relation to female genital mutilation', *Women and Birth*, vol. 31, pp. 25-30.

Varol, N., Hall, J.J., Black, K., **Turkmani, S.** & Dawson, A. 2017, 'Evidence-based policy responses to strengthen health, community and legislative systems that care for women in Australia with female genital mutilation/ cutting', *Reproductive Health*, vol. 14, no. 1, p. 63.

Conference Presentations

1. Turkmani, S., Homer, C., Dawson, A. (2019) Hearing women's voices: a study of the maternity care experiences and needs of migrant and refugee women with female genital mutilation, *Women Deliver Conference*, June 3-6, Vancouver, Canada.
2. Turkmani, S., Homer, C., Dawson, A. (2019) The Maternity Care Experience of Women with FGM in Australia. *3rd International Expert meeting on Management and prevention of Female Genital Mutilation/Cutting* May 20-21, Brussels, Belgium.
3. Turkmani, S., Homer, C., Varol, N. & Dawson, A. A survey of Australian midwives' knowledge, experience, and training needs in relation to female genital mutilation. *The Australian College of Midwives 20th National Conference*, November 2017. Adelaide, Australia.
4. Turkmani, S., Homer, C., Dawson, A., Midwives' experience, knowledge and needs regarding the care of women with Female Genital Mutilation in Australia. *31st ICM Triennial Congress*, June 2017, Toronto, Canada.

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Abbreviations

ABS	Australian Bureau of Statistics
AI	Appreciative Inquiry
AIHW	Australian Institute of Health and Welfare
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
HICs	High Income Countries
HREC	Health Research Ethics Committee
NGOs	Non- Governmental Organisations
NSW	New South Wales
PTSD	Post Traumatic Stress Distress/Disorder
QMNC	Quality Maternal and Newborn Care
RA	Research Assistant
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Child Fund
US	United States
UTS	University of Technology Sydney
WHO	World Health Organization

Glossary of terms

Female Genital Mutilation (FGM): Female genital mutilation (FGM) includes all procedures that involve the partial or total removal of the external genitalia or other injuries to the female genital organs (such as stitching of the labia majora or pricking of the clitoris) for non-medical reasons. World Health Organization (2016a) classified FGM in four types (I, II, III, VI) and, based on its severity, each type has its own sub-classification as explained here:

Type I (Clitoridectomy): Partial or total removal of the clitoris and/or the prepuce. **Type Ia:** removal of the prepuce/clitoral hood and **Type Ib:** removal of the clitoris with the prepuce.

Type II (Excision): Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. **Type IIa:** removal of the labia minora only, **Type IIb:** partial or total removal of the clitoris and the labia minora and **Type IIc:** partial or total removal of the clitoris, the labia minora and the labia majora.

Type III (Infibulation): Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris. **Type IIIa:** removal and appositioning the labia minora with or without excision of the clitoris and **Type IIIb:** removal and appositioning the labia majora with or without excision of the clitoris.

Type IV: All other harmful procedures to the female genitalia such as pricking, pulling, piercing, incising, scraping and cauterization for non-medical purposes.

Infibulation: It is the equivalent term for Type III that is explained above.

Re-infibulation: The procedure of sewing to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

De-infibulation: The practice of cutting open the narrowed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to avoid complications or facilitate childbirth.

FGM-equivalent terms used by women: ‘Khetan’, ‘Sunnat’, ‘Ferawni’, ‘Guduttan’, ‘Cut’, ‘Closed’, ‘Circumcised’, ‘Excised’.

Abstract

Background

Female genital mutilation (FGM) is a cultural practice defined as the partial or total removal of the external female genitalia for non-therapeutic reasons. Changing patterns of migration have resulted in clinicians in high-income countries caring for more women from countries where FGM is traditionally practised. Women affected by FGM who are pregnant and giving birth may require specialist care depending on their individual needs and type of FGM. However, many clinicians in these countries are unfamiliar with FGM, posing a challenge to the provision of quality of care. There is a lack of research in high-income countries that focuses on the maternity care experiences of women with FGM, that is necessary to ensure quality care.

Aim

The aim of this study was to explore the maternity care experience and needs of women affected by FGM who have migrated to Australia and to inform culturally safe and high-quality woman-centred care and contribute to maternity policy and practice improvements.

Method

Appreciative Inquiry was used as a collaborative approach to identify positive care experiences and create a participatory approach to engage women. Women with FGM were recruited through chain referral and the involvement of a community. Twenty-three semi-structured interviews and four focus group discussions (FGDs) were conducted in metropolitan Sydney. All data, including field notes, were analysed thematically using the 4Ds cycle of Appreciative Inquiry (Discovery, Dream, Design and Develop).

Results

Twenty-seven women affected by FGM from a range of countries participated in this study. The analysis revealed five major themes: (1) My FGM story, (2) appreciating the best in their experiences; (3) achieving their own dreams; (4) planning together; and (5) acting, modifying, improving and sustaining.

Subjective measures of ideal quality maternity care were identified based on women's perceptions and expectations. Women acknowledged the reality of maternity care and situations when it was not of the quality they desired or expected. Women reported that they were not always engaged in all aspects of their care. Most women expressed their desire to play an active role in their care, but they struggled with poor communication and a lack of information tailored to their individual needs. Women identified their meaningful involvement in the design and delivery of their care as a key strategy for improving and validating the quality of the maternity services they received.

Discussion

Women with FGM in this study had a clear understanding of their health and cultural needs. It is necessary to engage women as equals in the design and delivery of their own health care services. Such a level of partnership will ensure and sustain the quality of health services by centring woman and collaborating with them to deliver health care that meets their physical, emotional and cultural needs, thereby achieving quality care for affected women.

Conclusion

This study is one of the first of its kind in Australia and provides an understanding of policy, socio-cultural and healthcare gaps, and strategies required to build self-efficacy

and improve health outcomes for women with FGM. The findings from this research can be used as an advocacy tool or guideline to inform policy and practice and improve the quality of care for affected women through a participatory approach to co-designing future maternity care for women affected by FGM.